Texas Department of Aging
and Disability Services

Form 1547
July 2011-E

Regional Nurse/Dental Consultant Request Worksheet

1. Check All that Apply

Reason sending to nurse: ☐ Item not on approved list ☐ Exceeds service limit ☐ Medical need unknown ☐ Nurse consultation

Reason sending to dentist: ☐ Exceeds $5000 service limit (Must submit Form 3671-H & Form 3671-J for services approved in current ISP year)
☐ Within scope of dental services? ☐ Medical/Dental need unknown ☐ Cost effectiveness unknown

2. Individual's Name	3. Medicaid No.		
4. Residence ☐ AL/RC ☐ AFC ☐ Individual's own home	5. Individual's Area Code and Telephone No.		
6. Case Manager's Name	7. Mail Code	8. Unit No.	9. Area Code and Telephone No.
10. Case Manager Supervisor's Name		11. Mail Code	12. Area Code and Telephone No.
13. HCSS Agency Name	14. HCSS Agency RN Name		15. Area Code and Telephone No.
16. HCSS Agency E-Mail Address	17. Dentist(s) Name	18. Dentist(s) Area Code and Telephone No.	19. Dentist(s) E-Mail Address

20. Item(s) Requested: Include quantity and length of time needed, as appropriate. ☐ AA ☐ MS ☐ MHM ☐ Dental ☐ Other

21. Supporting Information: The case manager enters a check to indicate documentation submitted to regional nurse/dental consultant; the regional nurse/dental consultant enters a check to confirm the information was received.	**CM**	**RN/Dental Consultant**
A. Form 3671-1	☐	☐
B. Form 3671-F	☐	☐
C. Form 3672 or a statement indicating the item(s) is not covered by Medicare, Medicaid or other TPR	☐	☐
D. Form ☐ 3671-B ☐ 3671-C ☐ 3671-D ☐ 3671-E ☐ 3671-H ☐ 3671-J and ☐ 2060-A	☐	☐
E. Other supporting documentation, i.e. physician's order, product information, dental X-rays (if submitted by HCSS)	☐	☐
F. ☐ Current MN/LOC Assessment or ☐ Document Locator Number (DLN) _____	☐	☐

22. Case Manager's Comments: Include any previously approved similar items.

23. Case Manager Action Due Date _____ 24. Signature – Case Manager Submitting Request _____ 25. Date _____

26. Regional Nurse Determination/ Dental Consultant Recommendation
☐ Authorize _____
☐ Deny _____

27. Regional Nurse/Dental Consultant Comments:

28. Signature – Regional Nurse/Dental Consultant _____ 29. Date _____

30. To State Office ☐ Yes ☐ No | Date